Texas Medicaid SUD Background Document

Introduction/Background

Prior to September 1, 2010, Texas Medicaid had an individual and group outpatient Substance Use Disorder (SUD) counseling benefit for recipients <21 years old. Texas also had a hospital inpatient detoxification benefit for adults, although it was very restrictive (must have co-occurring medical condition).

However, in the Dallas service area Texas oversees a Medicaid 1915(b) behavioral health carve-out waiver, which was/is managed by the State Substance Abuse and Mental Health Authority, rather than the Texas Medicaid program. This carve-out began in 1999 and since inception has included a full array of SUD benefits for the Medicaid population. There has been an increasing awareness of the impact of SUD within healthcare. This interest, combined with available data from the Dallas carve-out, allowed the Texas Legislative Budget Board (LBB) to study whether expansion of the existing Medicaid benefit could be beneficial and cost effective. A link to that study is here:
http://www.lbb.state.tx.us/Documents/Publications/GEER/Government%20Effectiveness%20and%20Efficiency%20Report%202009.pdf#Abuse_Treatment

2011 update:
http://www.lbb.state.tx.us/Documents/Publications/GEER/GEER01012011.pdf#2011UpdateAbuseTreatment

In 2009, the Texas Legislature directed the Texas Medicaid program to expand the array of SUD services within Medicaid.

Texas implemented the expanded SUD benefit on September 1, 2010 to include a comprehensive benefit array for all Medicaid populations. This was phased in and the full benefit for fee for service and managed care enrolled recipients became available on September 1, 2011. These specific SUD benefits include:

Six SUD program benefits were listed in a document sent from HHSC to MCOs earlier this year (found here: https://www.hhsc.state.tx.us/medicaid/managed-care/mco-resource-docs/2014-11.pdf)

- Clinical assessment
- Ambulatory detoxification
- Outpatient individual and group chemical dependency counseling
- Medication assisted therapy (MAT)
- Residential detoxification
- Residential treatment

Note: Screening, Brief Intervention, and Referral to Treatment (ages 10-20), was a benefit that was implemented in 2009, independent of the expanded benefits noted above.

Additionally, through a network of providers, Texas also funds providers through the Substance Abuse Prevention and Treatment (SAPT) Block Grant. This is done via an RFP process. Block grant funded providers are also required to be Medicaid providers and, for Medicaid recipients,

must seek payment through the appropriate Medicaid payer (either the fee-for-service (FFS) Medicaid claims processor or Medicaid Managed Care Organization).

The LBB is currently in the process of evaluating the Medicaid SUD benefit expansion across a variety of metrics (penetration rates, cost/cost avoidance, etc.).

Early analysis on the comprehensive benefit implementation indicated relatively low penetration rates (relative to prevalence or historical penetration rates in Dallas carve out). This may have been due to several benefit implementation factors, including:

- Unfamiliarity of traditional providers to effectively navigate and function within a more complex, multi-payer system with managed care organizations (MCOs);
- Differing reimbursement and prior authorization methodologies between FFS and MCOs;
- Lack of expertise with SUD within MCOs;
- Lack of a Medicaid benefit that allows children to remain with a mother during treatment;
- Lack of partial hospitalization as an option;
- Low reimbursement rates; and
- Lack of awareness and information on the part of "consumers" that these services were available.

Staff is in the process of analyzing more current data to assess penetration rates and other metrics.

Research suggests significant overlap in populations served with mental health (MH) and SUD services. Recent changes to Texas' delivery system underscore the need to address both concurrently. In September 2014, Texas Medicaid "carved-in" mental health rehabilitation and targeted case management services into the MCO model. This carve-in was consistent with Texas' move to an almost an exclusive MCO model for delivery of healthcare services over the past several years.

Through participation in this learning collaborative, Texas hopes to advance the following:

- Learn about and promulgate best clinical practices within the Medicaid system, to include integrated care approaches (MH-SUD, and MH-SUD-Medical);
- Identify and promulgate efficient MCO and provider payment reform strategies that promote the best outcomes; and
- Identify the optimal set of measures to evaluate SUD and integrated care treatment and effectiveness.

Current Metrics Used for Medicaid SUD Treatment

NCQA/HEDIS Measures

- Identification of Alcohol and Other Drug Services (IAD)
- Initiation and Engagement of Alcohol and Drug Dependence Treatment (IET)

Pros: Nationally endorsed measure
Cons: Process Measures. Do not seem to measure "true SUD treatment" or outcomes

Potentially Preventable Events Measures (for SUD causes)

- Potentially Preventable Emergency Room Visits
- Potentially Preventable Hospital Admissions
- Potentially Preventable Hospital Re-Admissions

Pros: Outcome measures
Cons: Software does not capture all SUD related events

Homegrown Measures (calculated in the past and to be POTENTIALLY contemplated for future)

Client level, MCO/service area/county level analyses inclusive of ONLY the HCPCS codes/modifiers utilized in the expansion:

- Penetration rates into specific services
    - MCO or fee for service
    - Variation
- Cost
- Provider activity/patterns
- Assess client movement through continuum and duration of treatment relative to outcomes
- Effectiveness of services
- Integration with other services

Pros: More granular and specific
Cons: No standardized measurement

Some Areas of Future Focus

- Comparison with "super-utilizers"
- Neonatal Abstinence Syndrome

Payment Reform

Texas Medicaid also recognizes that MCO and provider payment reform is a crucial ingredient to quality improvement and reduction in costs. As such we have an MCO Pay for Performance program, although SUD is not a specific targeted measure. Additionally, Texas Medicaid has begun to require MCOs to expand their provider reimbursement models to more quality based payment structures. This is in the early stages.

Through this learning collaborative, we hope to learn how we can most effectively measure SUD effectiveness (and integrated care service provision), as well as understand/promote payment models that support best clinical practices.